MEDICAL HOME MODELS
March 17, 2011

1. **The Physician Practice Connections ® - Patient Centered Medical Home (PPC-PCMH™)** developed by the National Committee for Quality Assurance (NCQA) in collaboration with the American Academy of Family Physicians (AAFP), American College of Physicians (ACP), American Academy of Physicians (AAP), American Osteopathic Association (AOA) (collaboration that has developed **Joint Principles of the Patient-Centered Medical Home)**:

    a. NCQA PPC-PCMH: http://www.ncqa.org/tabid/629/Default.aspx

    b. Joint Principles of the PCMH: http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home

2. Primary Care Assessment Tools by Starfield and Cassidy: http://www.jhsph.edu/pcpc/pca_tools.html

    This set of tools consists of: a) Consumer-client surveys; b) Facility surveys; c) Provider surveys; and, d) Health system survey (in preparation).

3. Assessment of Chronic Illness Care developed by Wagner et. al.

    a. Chronic Care Model: http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

    b. Assessment of Chronic Illness Care (ACIC) survey: http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/Tools/ACICSurvey.htm

4. Medical Home Index developed by Cooley and McAllister: http://www.medicalhomeimprovement.org/

5. State-defined Medical Home models (Building Medical Homes in State Medicaid and CHIP Programs, The Commonwealth Fund, June 2009: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Jun/Building%20Medical%20Homes%20in%20State%20Medicaid%20and%20CHIP%20Programs/medicalhomesfinal_revised.pdf):

    a. **Colorado**: "Medical Home" means an appropriately qualified medical specialty, developmental, therapeutic, or mental health care practice that verifiably ensures continuous, accessible and comprehensive access to and coordination of community-based medical care, mental health care, oral health care and related services for a child. A medical home may also be referred to as a health care home. If a child's medical home is not a primary medical care provider, the child must have a primary medical care provider to ensure that a child's primary medical care needs are appropriately addressed. All medical homes shall ensure, at a minimum, the following:

        (a) health maintenance and preventative care;
        (b) anticipatory guidance and health education;
        (c) acute and chronic illness care;
        (d) coordination of medications, specialists and therapies;
        (e) provider participation in hospital care; and
        (f) twenty-four hour telephone care.

    Source: State legislation
    http://www.coloradomedicalhome.com/#&slider1=4

b. **Minnesota**: The standards developed by the commissioners must meet the following criteria:

   i. emphasize, enhance and encourage the use of primary care and include the use of primary care physicians, advanced practice nurses and physician assistants as personal clinicians;

   ii. focus on delivering high-quality, efficient and effective health care services;

   iii. encourage patient-centered care, including active participation by the patient and family or a legal guardian, or a health care agent as defined in chapter 145C, as appropriate in decision making and care plan development and providing care that is appropriate to the patient's race, ethnicity and language;

   iv. provide patients with a consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care for the patient's condition;

   v. ensure that health care homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including an assessment of health risks and chronic conditions;

   vi. enable and encourage utilization of a range of qualified health care professionals, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license;

   vii. focus initially on patients who have or are at risk of developing chronic health conditions;

   viii. incorporate measures of quality, resource use, cost of care and patient experience;

   ix. ensure the use of health information technology and systematic follow-up, including the use of patient registries; and

   x. encourage the use of scientifically based health care, patient decision-making aids that provide patients with information about treatment options and their associated benefits, risks, costs and comparative outcomes and other clinical decision support tools.

   Source: 2008 Minnesota statute
   http://www.health.state.mn.us/healthreform/homes/

c. **North Carolina**: Carolina ACCESS is North Carolina's Medicaid managed care program. It provides you with a medical home and a primary care provider (PCP) who will coordinate your medical care. What is a medical home? A medical home:

   xi. offers the very best of care for you. The staff will know you and your medical history. They will coordinate your health care with other doctors who may need to treat you;

   xii. can be a doctor's office, a community clinic, or a local health department;

   xiii. provides a PCP you can call for help when you need to. You no longer have to go to the emergency department when your problem does not threaten your life or risk your health without immediate treatment; and

   xiv. provides treatment and/or medical advice 24 hours a day, 7 days a week.

   Source: Carolina ACESS member handbook
   http://www.communitycarenc.com/

d. **South Carolina:** Healthy Connections, voluntary – with a combination of Managed Care Organizations and Primary Care Case Management/Medical Homes Networks
Emphasis on quality improvement and cost containment:

- Establishment of stable medical home for beneficiaries
- Care Coordination and Care Management
- Disease Management
- Pharmacy Utilization Management
- Ensured access to care with a focus on rural areas

http://www.scchoices.com/SCSelfService/en_US/index.html

e. **Oregon**: Primary care medical home can generally be characterized as a primary care practice which provides the following to its patients: a continuous relationship with a physician; a multidisciplinary team that is collectively responsible for providing for a patient's longitudinal health needs and making appropriate referrals to other providers; coordination and integration with other providers, as well as public health and other community services, supported by health information technology; an expanded focus on quality and safety; and enhanced access through extended hours, open scheduling and/or email or phone visits.

Source: The Medical Home Model of Primary Care: Implications for the Healthy Oregon Act
http://www.ohsu.edu/cdrc/medicalhome/index.html

f. **Washington**: An approach to providing health care services in a high-quality, comprehensive and cost-effective manner. The Washington State Department of Health describes core elements of a medical home as:

- Compassionate and Culturally Effective
- Coordinated and Comprehensive
- Family-centered
- Accessible and continuous

Programs must be evidence-based, facilitate the use of information technology to improve quality of care, acknowledge the role of primary care providers and include financial and other supports to enable these providers to effectively carry out their role in chronic care management and improve coordination of primary, acute and long-term care for those clients with multiple chronic conditions.

Source: Senate Bill 5930 Chapter 259
http://www.medicalhome.org/

6. Evolving Models of Behavioral Health Integration in Primary Care, Milbank Memorial Fund, 2010, http://www.integratedprimarycare.com/Milbank%20Integrated%20Care%20Report.pdf